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TRANSLATION FROM RUSSIAN*. LESHCHINSKAYA, F. V. (1964)**. Differential diagnosis of hemorrhagic fever of the Crimean type. (Abstracts of papers of the 11th Scientific Conference of the Institute of Poliomyelitis and Encephalitis). In: Tick-borne encephalitis, Kemerovo tick-borne fever, hemorrhagic fevers, and other arbovirus infections. Moscow, pp. 268-270.

While working in epidemiological foci of tick-borne hemorrhagic fever in Astrakhan Oblast, it was frequently necessary to differentiate this illness from Werlhof's disease, capillary toxicosis, hemorrhagic form of agranulocytosis, influenza, and alimentary toxinfection.

The most important manifestations of Crimean hemorrhagic fever in differential diagnosis are: acute onset, with general infection signs (chills, rheumatic pains, etc.), hemorrhagic syndrome, which appears at definite periods of the illness (most frequently between day 3 and 10), bradycardia, hypotonia, epigastric and lumbar pains, recurrent vomiting, leukopenia, and thrombocytopenia. Hemorrhagic rash first appears on the upper half of the body, usually along the posterior axillary lines, in elbow bends, and is very characteristic in inframammary glands of women.

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* This translation was made for members of the U.S. Hemorrhagic Fever Delegation to the USSR and for other interested persons.

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Recurrent waves and relapses were not noted.

As a rule, in contrast to tick-borne hemorrhagic fever, Werlhof's disease proceeds without febrile reaction and signs of general intoxication, and is characterized by numerous relapses during the life course of a patient.

For differential diagnosis of capillary toxicosis, the character of arrangement of cutaneous inflammations may have a definite role. In capillary toxicosis, symetrical arrangement of hemorrhagic elements on the skin is characteristic and, in contrast to tick-borne hemorrhagic fever, appear most frequently on the inferior extremities and localize in the articulation regions, accompanied by painfulness and sometimes edematization of the latter. Bradycardia absent. Neutrophilic leukocytosis is noted in the peripheral blood. The number of thrombocytes is normal or slightly decreased. Relapses of illness are possible.

Hemorrhagic form of agranulocytosis differs from tick-borne hemorrhagic fever by presence of a great number of immature forms of leukocytes in the blood, protracted character of the disease with recurrent waves of hemorrhagic manifestations, and enlargement of the liver and spleen. In patients ill with tick-borne hemorrhagic fever, pronounced leukopenia is frequently noted, shift to the left, usually up to the rod neutrophil leukocytes, less frequently up to the immature leukocytes and myelocytes. However, as a rule, restoration of normal amount of leukocytes and blood formula occurs rapidly, in the course of 5 to 10 days.

In cases with a mild course of tick-borne hemorrhagic fever and weakly pronounced hemorrhagic syndrome, the necessity of differentiation from

influenza arises. In these cases, in favour of diagnosis of tick-borne hemorrhagic fever, testifies summer season of appearance of disease, data of epidemiological anamnesis (tick-bite, working in nature, etc.), presence of epigastric and lumbar pains, recurrent vomiting, and high degree of leukopenia (1500 - 2000), considerable albuminuria (1% and more) with absence of other coarse pathology in urine.

In the same category of patients, owing to presence of vomiting and pains in the epigastrium, differential diagnosis of alimentary toxinfection is carried out. Against the latter, leukopenia, hyperemia of face and sclera, and bradycardia, are indications.